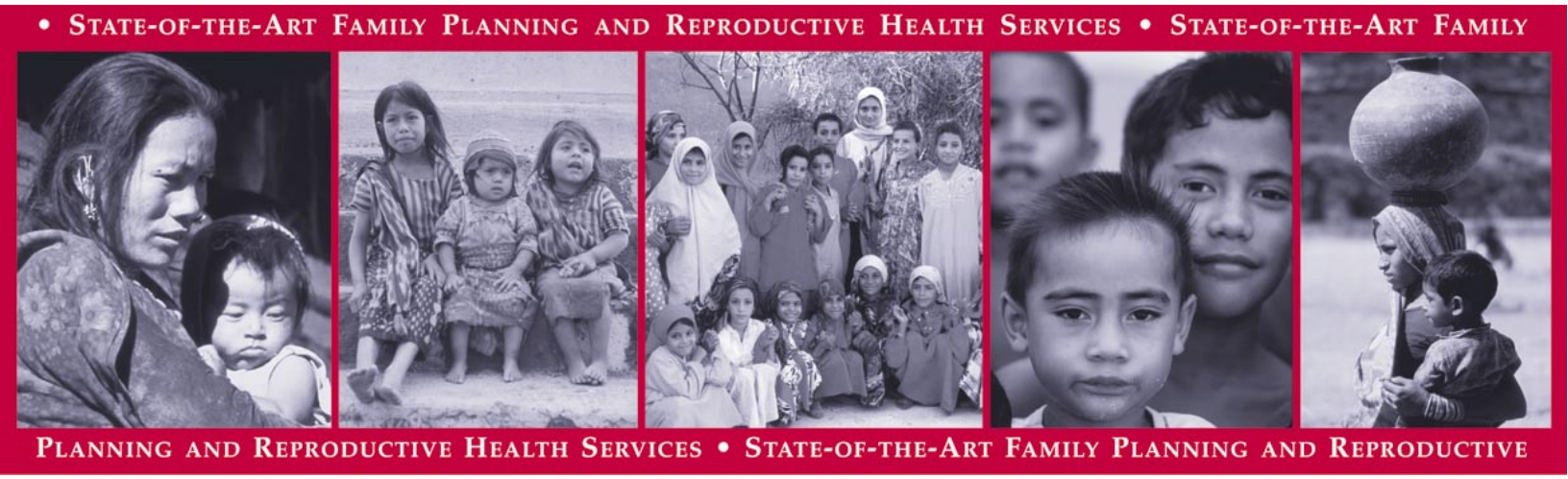


# BOLIVIAN FOCUS GROUPS ON BIRTH SPACING

## Qualitative Study in Bolivia

**2003**

CATALYST
consortium

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## Qualitative Study in Bolivia

**(One in a series of five country studies, including Egypt, India, Pakistan and Peru)**

**2003**

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Bolivian Team responsible for the Study:
Beatriz Espinoza

Review and Institutional Support:
José del Barco, Medical Advisor, PAC, in Bolivia

CATALYST Review Team:
Reynaldo Pareja, Senior Advisor, Behavior Change Communications
Paula Hollerbach, Evaluation Officer
Sally Salisbury, Communications Officer

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## I. INTRODUCTION

The Optimal Birth Spacing Initiative (OBSI) is an activity of the CATALYST Consortium designed to place optimal birth spacing on the global public health agenda by instituting a recommendation for three-to-five year birth intervals at the policy, programmatic and behavioral levels. The objectives of OBSI are: (1) to create consensus among international organizations and program managers on the strong association between birth intervals of three to five years and improved maternal and child health outcomes; (2) to strengthen health services, provider training and community programs with birth spacing programming; and (3) to empower individuals and families to adopt birth spacing behaviors. To collaborate on the Initiative, CATALYST has gathered a group of Birth Spacing Champions as an ongoing working group, including over 30 representatives from USAID, UNICEF, and interested cooperating agencies (CAs), nongovernmental organizations (NGOs), academics and researchers.

CATALYST has collected and commissioned quantitative research on the health impact of optimal birth spacing. This research shows that when births are spaced three to five years apart there are substantially more health benefits for neonates, infants, children and mothers than the previously recommended two-year birth spacing interval. Research findings from North America, Asia, the Middle East/North Africa, Latin America/Caribbean and sub-Saharan Africa have shown the following:

- Short birth intervals are a key risk factor for maternal and perinatal morbidity and mortality. This effect remains when the data are statistically controlled for socio-demographic and biological variables (Conde-Agudelo and Belizan, 2000; Fuentes-Aflick et al., 2002; Zhu et al., 1999; Zhu et al., 2001).

- The lowest perinatal mortality occurs with a 36-47 month birth interval and the fewest miscarriages occur with 24-35 month birth intervals (Rutstein, 2002).

- Women with birth intervals of less than 15 months, have 2.54 times the risk of maternal death compared to women with birth intervals of 27-32 months. Women with long birth intervals (>69 months) have a higher risk for adverse maternal outcomes such as preeclampsia and eclampsia (Conde-Agudelo and Belizan, 2000).

- In Latin America adolescents aged 15-19 comprise 80% of the group with the shortest birth intervals. Adolescents age 16 years are four times more likely to die of pregnancy-related causes compared to mothers aged 20-24 years. Infants of these mothers face an increased risk for low birth weight, small for gestational age and preterm delivery (Conde-Agudelo, 2002).

- There is a substantial demand for birth spacing among young and low-parity women, and a demand among zero-parity women to delay their first births (Jansen et al., 2002).

As part of the OBSI strategy, CATALYST has commissioned qualitative research in order to better understand the many and complex issues that shape reproductive health and spacing behaviors. Focus group studies were conducted in five countries – Bolivia, Peru, India, Pakistan and Egypt. Reports from each country will be available on the CATALYST web site with an additional cross-countries analysis to determine commonalities. Findings from the focus groups will provide the foundation for developing optimal birth spacing guidance, counseling materials, and training guidelines and will also foster collaboration between the public, private and NGO sectors.

## II. METHODOLOGY

This report was conceived as an exploratory qualitative study in a limited number of cities. The goal of the study was to identify the opinions and actions, with respect to optimal spacing between births, of women who space and do not space their births, their male partners and health care providers involved in reproductive health services.

This study used four subject guides for the four types of participants. Each focus group session lasted one and a half hours using the corresponding guide. Members of each group were allowed to express themselves freely and spontaneously, which permitted a large amount of relevant information to be collected for the study.

The findings in this report are derived from focus groups conducted in Bolivia at El Alto de La Paz and Cochabamba. Fieldwork took place between July 24 and September 12. Two teams in the two cities, each consisting of one psychologist and six recruiters, were responsible for the work.

The participating population included poor women (mothers) and male partners between the ages of 15 and 30, as well as health care providers of sexual and reproductive health services.

**Distribution of Focus Groups**

| CATEGORY | LOCATION | AGE | NO. OF GROUPS | NO. OF AUXILIARY GROUPS | TOTAL |
|---|---|---|---|---|---|
| Women who have spaced births | Peri-urban La Paz | 15-19 | 2 | 1 | 3 |
| | | 20-30 | 2 | | 2 |
| | Peri-urban Cochabamba | 15-19 | 2 | | 2 |
| | | 20-30 | 2 | | 2 |
| Women who have not spaced births | Peri-urban La Paz | 15-19 | 2 | 1 | 3 |
| | | 20-30 | 2 | | 2 |
| | Peri-urban Cochabamba | 15-19 | 2 | | 2 |
| | | 20-30 | 2 | | 2 |
| Male partners | Peri-urban La Paz | 15-30 | 2 | | 2 |
| | Peri-urban Cochabamba | 15-30 | 2 | | 2 |
| Health care providers | Peri-urban La Paz | Providers of sexual and reproductive health services | 2 | | 2 |
| | Peri-urban Cochabamba | Providers of sexual and reproductive health services | 2 | | 2 |
| TOTAL | | | 24 | 2 | 26 |

### A. Focus Groups Structure

The study consisted of 24 focus groups (twelve in each city) with an average of eight participants each. All focus group sessions took place in appropriate rooms over a two-week period, and all the sessions were recorded.

A psychologist led the research team. The psychologist also worked with recruitment teams (12 recruiters in all) in each city. Recruitment guidelines were as follows:

- Specific age range, 15 to 30 for women (spacers and non-spacers)
- Specific age range, 15 to 30 for male partners
- Low socioeconomic level, peri-urban area
- Sexual and reproductive health services providers

The study sought to identify and analyze the knowledge, attitudes and practices of participants, in the different individual, cultural and institutional environments.

### B. Focus Group Guidelines

The focus groups guidelines were structured for all audiences (women spacers and non-spacers, male partners and health care providers) in the same way:

- Individual level (knowledge, beliefs/attitudes, practices)
- Cultural level (norms)
- Institutional level (service)
- Information sources

### C. Consent Considerations

In accordance with the study methodology, all participants were informed of the purpose and potential risks and benefits of participation in the focus groups. All participants provided their written consent. They were also informed that their responses could be quoted in this report, but their identity would not be disclosed. Additional procedures to secure and store the data were also explained.

## III. STUDY OBJECTIVES

- Identify the knowledge, attitudes and practices of the peri-urban population in two cities (El Alto and Cochabamba) in Bolivia with respect to birth spacing, its implications for the woman, the couple, as well as the last and next child.

- Identify the advantages or disadvantages of delaying a new pregnancy after a birth, for the woman, the couple and the previous child.

- Identify use of contraceptive methods.

- Identify the length of spacing between pregnancies that the community considers adequate.

- Determine which partner makes the decision regarding a new pregnancy.

- Identify the family or community member who influences the decision regarding a new pregnancy; the role of religion and the role of the health service provider.

- Determine what kind of birth spacing information was offered at the health services.

- Identify the information sources the community could use to learn about the benefits of delaying a new pregnancy.

- Determine where participants want to access birth spacing information.

- Determine what health care providers know and what information they need in order to counsel users.

## IV. PRESENTATION OF RESULTS

This section describes the participants' opinions on knowledge, attitudes and practices regarding the topics established in the terms of reference of the study. This analysis examines the beliefs and practices of women who have practiced birth spacing for two years and women who have not in two age groups (15-19 and 20-30 years old), men (15-19 and 20-30 years old) and health care providers of El Alto and Cochabamba with regard to birth spacing.

### A. Main Findings

- All groups see more advantages to the mother, child and family economics with longer birth spacing, but admit that in practice the women get pregnant sooner than desired.
- In general, the minimal birth spacing period for most groups is considered to be two years, with optimal birth spacing between three and five years.
- Men exert control and impose their will when it comes to sexual relations, regardless of whether or not the woman wants to engage in sexual relations for fear of becoming pregnant.
- In reality, pregnancy "just happens" it is not something that the couple consciously talks about, plans for and acts on accordingly; when pregnancy occurs, it must be accepted as destiny or God's will.
- The Catholic Church is not opposed to spacing between births, but most strongly promotes "natural" prevention (such as calendar method and LAM) and dialogue between couples; other Christian denominations as well as the Catholic Church believe women should not use contraceptive methods because they interfere with the natural conception process, so their use is considered to be sinful and is prohibited.
- The family and friends exert pressure on too short or too long spaced pregnancies based on cultural beliefs: the woman has to show fertility; the man has to prove virility.
- Pharmacies are considered poor sources of information on birth spacing; doctors are more trusted; nurses are not considered helpful or friendly.

## B. Perceived Advantages and Disadvantages of Birth Spacing for the Woman, her Partner, the last Child and the Newborn

In this section, we present the findings regarding the beliefs that women, men and health care providers have with respect to their perceived advantages and disadvantages of spacing births more than two years apart. One aspect that was common to all participants was that they generally favored longer intervals between pregnancies. A second aspect was the agreement of all groups that it is easier for a woman to calculate when to get pregnant than to calculate when the next child should be born.

### Advantages

**For women:**

Women of both age groups, including those who spaced and those who did not, considered that birth spacing was beneficial. While they do not all agree on a specific birth interval, they believe it should be somewhere between two and five years.

The advantages of birth spacing that women recognize can generally be divided into four categories: economic conditions, mother's health, childcare and development and personal development.

Birth spacing allows women to help their families achieve better economic conditions, avoids the expense of a new child and permits savings. It also gives women the opportunity to join the workforce, which guarantees an economic income.

Advantages are also perceived in personal development, especially for adolescent mothers. This assumes two lines of growth:

- The first seeks to improve the personal image or the building of self-image (Self-image is considered a visible component of self-esteem). In this sense, women believe that resting between pregnancies gives them freedom and the time to be able to care for themselves and recover physically.

  *"...They do not become worn out..."*

In this context, as women report, the care of children is no longer viewed as a burden. They feel revitalized, creating a "new mother" who "feels proud" and who has the capacity to "give love." Moreover, they are able to invest savings in clothing and supplies. These factors make them feel better about themselves and their roles as mothers.

- The second line of personal development proposes that the time and freedom resulting from birth spacing is used to seek employment and continue or begin studies. Both women and health care providers in the study share this belief.

  *"...We can gain more experience..."*

Health care providers believe that spacing enables mothers to overcome the physical deterioration resulting from pregnancy, especially with regard to the womb. Also spacing promotes the breastfeeding process, the prevention of diseases such as anemia and

malnutrition, which can result from successive pregnancies, and the prevention of complications of pregnancy and birth that may cause maternal and infant deaths.

To summarize, participants believe birth spacing offers considerable benefits to the woman: easing economic conditions, enabling her to recover physically and maintain her health, pursue her life objectives, and give her children more attention and better care.

**For men:**

The women said that men do not assume direct responsibility for child rearing; rather, they are responsible for the family's economic stability. The advantage of birth spacing for men is that they do not feel pressured to increase their income to sustain the household. Moreover, women can help men in their work or in supporting the household.

> *"…Economically it is going to help us reduce expenses…"*

Men and providers in El Alto and Cochabamba report that birth spacing has a direct effect on finances, since they would not spend more money on a new child and therefore can save money and enjoy greater peace of mind, especially during the country's current crisis, in which jobs are scarce and wages are low.

They also consider birth spacing an advantage because their wives can spend more time with them and can use that time to acquire knowledge and skills to raise future children.

> *"...The wife has more time to take care of us (the men)..."*
> *"...They can learn more skills..."*

**For the last child and the newborn:**

According to study participants, birth spacing permits the creation of a family environment that is favorable for the care and development of the last child.

The advantages for the newborn are that she receives better quality and quantity of care. *"Warmth," "understanding"* and *"serenity"* accompany *"care," "games"* and *"learning,"* which facilitate the child's development and growth.

By spacing births further apart, the mother has more time and more freedom to care for her child and the family. She and her partner feel less pressured in terms of responsibilities and earning income to maintain the household and provide for the children. These factors reduce the tension in the relationship and create a warm, responsive atmosphere.

The responsibility parents assume in the child's development also has an impact on health. Participants believe that devoting more time to the child leads to good health and habits such as *"cleanliness," "order"* and *"respect."* Moreover, the child receives improved nutrition because she is able to breastfeed for a longer period.

All focus group participants have similar beliefs with respect to the advantages for the last child. In summary, participants believe that birth spacing is beneficial to the last child since she enjoys a better relationship with parents in terms of quantity and quality of time

dedicated to child rearing, which assures her rapid psychomotor, emotional and physical development, thereby contributing to her autonomy.

Since the family forms a unit, there is a direct relationship between the advantages of birth spacing for all members. In this sense, study participants reported that the "experience," "serenity" and "maturity" parents acquire over time and the experience they gain in caring for one child puts them in a better position to deal with a new pregnancy.

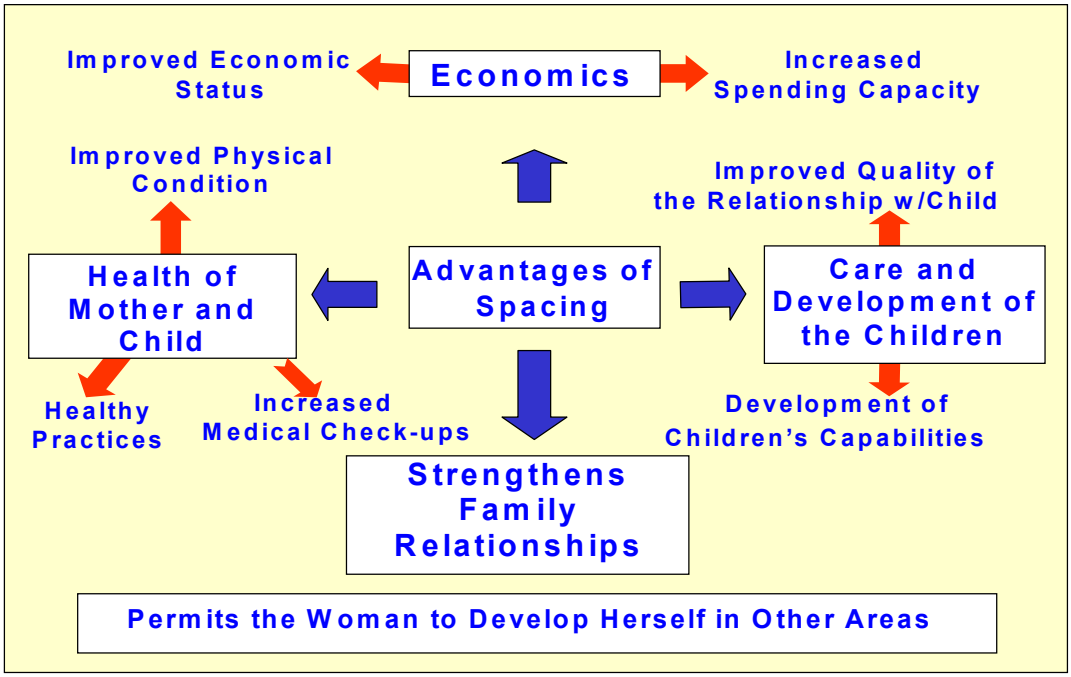
If birth spacing is achieved for more than two years and the next pregnancy is planned, then the next child is *"wanted."* The baby will have *"love," "attention"* and the necessary concern of her parents.

This environment of care and personal development of the new child will be accompanied by some economic stability, thereby helping to assure that the child's basic needs are satisfied. Mothers, in particular, report that they can feel *"prouder"* of the newborn since she will be born well-developed, strong, and weighing an appropriate amount.

All focus group participants agreed that the child would enjoy a better relationship with her parents and older siblings. In most cases, the older sibling who is already autonomous in his daily activity will help to care for the newborn, which the parents feel is advantageous.

The following figure summarizes the perceptions of women, of men and of health care providers who participated in the focus groups regarding the advantages of birth spacing.

**Fig. 1. Advantages of Birth Spacing for the Woman, Couple, Newborn and Last Child**



**Disadvantages**

According to the women in the study, birth spacing has no disadvantage for their health or personal development. It does affect their relationship with their partners, however, since the men generally do not support their decision to use contraceptives, they are suspicious of women if they use them, or they simply want to continue having children. This leads to a tense relationship marked by distrust and jealousy.

Health care providers share these beliefs. They claim that men pressure women to engage in sexual relations without taking into account whether or not they are at risk of pregnancy. Male partners are particularly prone to this attitude when they have been drinking, and they often do not accept the woman's refusal.

Women and health care providers report that a woman's decision to use contraceptives is in many cases considered by their partners as a sign of infidelity or lack of love, and therefore strains the relationship and encourages jealously and suspicion, which in some cases may even lead to abandonment of the partner.

*"They are unfaithful…they don't love us…"*

The various participants of the study did not believe that there were disadvantages for the last child in terms of health, care and personal development. They did see a possible disadvantage of birth spacing in the relationship between siblings, particularly in regard to play.

There is a belief, confirmed by some concrete experiences, that a large age gap between siblings will make them incompatible as playmates and will cause them to have a conflicted relationship; they will have trouble playing together and they will develop individualistic, selfish and capricious personalities, which will complicate child rearing. Furthermore, too long an interval between births will not allow the newborn to use the clothes of her older sibling.

Study participants believe that if the spacing is too long (five years), the children will be very different, growing up *"lonely," "envious," "capricious"* and *"rebellious."* There is also the belief that the parent will have more difficulty playing with the child. Additionally, if the mother is working or studying, she will not be able to fully dedicate herself to the newborn.

Finally, study participants said that spacing could affect the relationship between parents and the newborn. The parents who have the time and freedom because of spacing to have begun new employment or study activities will have to disrupt their daily schedules when the child is born.

### C. Actual Birth Spacing Practices

According to health care providers, women wait an average of one year between pregnancies, with periods ranging from four months to one and one-half years. These data do not vary between cities or between births. However, there is a difference in terms of age, since younger women become pregnant more frequently while women approaching 30 and having had two or more children increase their spacing.

In all cases, the women said that they would have preferred to wait longer. They said that they wanted their partners, family and health care providers to show understanding and to provide guidance and information on the correct application of a contraceptive method.

**D. Couples' Decision-Making Process Regarding New Pregnancies**

Couples make decisions based on different considerations. In relation to birth spacing, these include information, customs, expectations, the concept of the family as well as the position and authority of each family member.

Based on the focus group discussions, there is really no decision-making about becoming pregnant. There are very few cases in which the couple has sexual relations in order to get pregnant; generally, sexual activity takes place to satisfy the sexual needs of the couple, particularly of the man.

> *"...He doesn't decide because he doesn't know, it's just his instinct..."*
> *"...It's not a decision, it's just an accident..."*
> *"...There is no decision, it is a natural act..."*
> *"...Sexual satisfaction is the most important thing for men..."*

Conflict occurs in the couple's relationship because the woman knows when she is at risk of pregnancy but does not use any form of protection, for which reason she may become pregnant. As a result, the sexual relationship becomes tense, forced and in some cases violent. Adult women who did not use spacing were especially likely to mention these characteristics.

> *"...It's the man's fault..."*
> *"...It's because of the pressure the man puts on his wife. Some wives want to use protection, but their husbands won't let them..."*

Sexual relations take place from the perspective of sexual satisfaction rather than planning. The pleasure of the moment is more important for men rather than the long-term consequences. In this sense, becoming pregnant is an accident that occurs simply because of instinct.

> *"...Neither partner knows how to plan..."*
> *"...When the man wants to have relations, he does not use protection.*
> *"…Men are just machistas..."*

The prevailing macho culture in Bolivian society and particularly in this population group is not questioned. It is accepted as the natural way that a male-female relationship takes place. Men and women do not contrast these values with new information on individual rights and responsibilities.

This lack of information also translates into a lack of guidance. Young women in both cities believe they do not have much information. They claim that if they had received guidance from their parents, partner or health care provider, they could have prevented the pregnancy.

The men in the study claim that people living in rural and peri-urban areas have little access to information and guidance. In the cities, this deficiency is addressed by the mass media, such as radio and television, which provide some information for decision-making.

*"...I think it's due to a lack of information and guidance..."*
*"...Most do not plan, it just happens, because there is no information in rural areas..."*

In the few cases in which a decision regarding pregnancy was made, the man, the woman or both made the decision.

*"...The couple decides if they want to have a child..."*
*"...I think that it is the woman because she has to live with the children more, and the man supports her..."*

According to the men, women are the ones who make the decision to become pregnant, since they are directly responsible for their children's care and development with the men's support.

*"...Pregnancy occurs because the two come together and obviously if you want one, you have to sleep together. The woman decides when she wants to do it..."*

Older women said that men are the ones who make the decision for them to become pregnant, which must be obeyed. They must agree to have sexual relations to prevent conflict with their partners.

*"...The man has to decide..."*

According to a small group of women from La Paz, women are the ones who make the decision since they have to suffer through the process.

*"...In some cases, the woman decides..."*

The decision-making process, when it takes place, is through conversations in which economic conditions, the need for the older sibling to have a companion, and the age and health of the woman are all discussed. In some cases, the man makes the decision without consulting the woman, and the decision must be obeyed without argument.

*"...We come to an understanding to avoid having more kids..."*
*"...In the end, they come to an agreement..."*

In light of the information obtained, the man appears to have the greatest influence on the pregnancy outcome. As head of household, he has the authority to make the decision when to have sex, which must be obeyed.

To summarize, the participants believe that no decisions are made regarding a new pregnancy. Becoming pregnant is simply an "accident" resulting from the couple's desire for sexual satisfaction, particularly the man's. The couple engages in sexual relations on high-risk days without using protection, resulting in unwanted, unspaced pregnancies.

## E. Family or Community Influence on the Decision for New Pregnancies

### Family

The first influence comes from the women of the female partner's family (mothers, grandmothers or sisters), who give advice to the woman on family and relationship issues. The second outside influence is mothers-in-law and sisters-in-law, who not only give advice, but also impose their views on the couple's relationship. This is often the case, especially for younger women who have spaced their pregnancies. These criteria can lead to conflict in the relationship.

> *"...The mother-in-law has an influence; sometimes there are fights, they call us mules..."*

The third ring of influence on the decision to become newly pregnant is comprised of friends and neighbors, who exert their influence through advice and criticism. In the case of adolescent women, friends have more influence, while neighbors have more influence in the case of adult women.

### Community

With respect to the influence of different people with whom the couple maintains ties, participants mentioned that there is no real punishment or sanction against them, since they believe that no one can judge them for their actions. They believe they can make decisions as a couple. This position is much more frequent among adult women and men.

Participants do recognize some moral pressure and sanctions that may make the couple feel ashamed. The criticisms are associated with the following:

- The waiting period
- The woman's age
- The number of children
- The capacity to have them

With respect to the birth spacing period, relatives, friends and neighbors start asking questions when the period is too short or too long. When the period is short, relatives complain because they are aware of the effects on the health of the woman and the children. When the period is too long, they question whether siblings will be able to have a good relationship.

> *"...When a woman gets pregnant quickly, the family begins to scold her..."*
> *"...When the spacing is short, they say 'not again'..."*
> *"...When the spacing is long, they say 'she's lazy'..."*

Concern is also expressed in the community when the woman is older and wants to have more children. People may ask her how many she wants to have.

> *"...If a woman waits till she's older to have a baby, people ask, 'how are you going to have one'?..."*

The number of children is also a topic of discussion in the community. When a family has many children, the family is criticized because of the economic and childcare difficulties involved. A frequently heard expression is "you're like a rabbit." Couples who have few or no children are also ridiculed. The virility of the man and fertility of the woman is questioned. This occurs especially when the woman is older, particularly in El Alto.

*"...They say 'now you can't have any, you're sterile'... "*
*"...Men hassle their friends, they say, 'you can't have any more'..."*

Social sanctions are more frequent in rural areas. Fertility is considered sacred and women are expected to be fertile. If a woman is somewhat infertile, she is ostracized and called a mule.

*"...In rural areas, it is a sin to be infertile, the woman is an outcast; they call her a mule..."*
*"...Fertility is sacred..."*

Other people also influence this decision, particularly other female relatives. This influence assumes the form of advice or pressure, which can create conflict within the relationship. Friends and neighbors are also important advisors and judges of this decision. The influence of these actors is stronger among adolescent couples than among adult couples.

In general, the community exercises pressure and in rural areas, couples may be ostracized, particularly the women. Generally speaking, fertility is considered sacred, for which reason the spacing period, woman's age, number of children and the capacity to have them are questioned. Couples should not have too many or too few children, should not be too young or too old, and should not wait too little or too long between pregnancies.

### F. Most Recommended/Requested Contraceptive Methods

Health care providers participating in the focus groups reported that they offer information on *"natural," "modern,"* and *"definitive,"* family planning methods, which was confirmed by other study participants, particularly the women.

This information is offered mainly to women who go to health centers for pre-natal checkups, children's checkups or for treatment of a family member with a health complaint.

Postpartum care is irregular since women generally stop going to facilities after they give birth. For this reason, health care providers believe that the best time to discuss contraception with mothers is immediately after they give birth. It is during this period that women often decide they do not want additional children. Health care providers may offer to insert an IUD at this time and, according to some women, pressure them to accept this method.

According to providers the contraceptive methods offered at health facilities are: IUDs, Depo-Provera injections, condoms and birth control pills, and information about "natural " methods (such as calendar method and LAM). Permanent methods such as tubal ligations are also offered. Only one provider reported offering vasectomies to men.

According to women from both cities and from both age groups, the most commonly offered methods are IUDs, Depo-Provera injections and condoms (condoms are more popular among younger groups). Several participants believe that using the IUD causes cancer (women of both age groups) and that it can increase a woman's sexual appetite, which causes her to be unfaithful (men's opinion). Depo-Provera injections are said to produce side effects that alter and affect the woman's body. Despite these beliefs, women who choose to use modern contraceptives frequently opt for these two methods.

Respondents in the focus groups gave the following reasons for making a decision to use one of these methods:

- Health care providers pressure women to use a particular method.
- Women decide to use it without the consent or knowledge of their partners.
- Women and their husbands decide to use one of these methods.
- The husband pressures his wife to use one of these methods.

## Contraceptive strategies

In light of focus group discussions, there seems to be a weak concept of family planning. Furthermore, health care providers apparently introduce contraceptive methods to users but do not discuss the basic idea of planning when and how many children to have, nor do they discuss the social and cultural elements of this decision.

Additionally, men (partners) show a lack of interest in learning about or using a contraceptive method. Women have little if any power to make a decision about family planning. As a result, in most cases, women do not even question the men's decision to have sexual relations.

The need to avoid pregnancy leads some women to a type of short-term contraceptive strategy, such as preventing pregnancy during the month. According to focus group participants, this contraceptive strategy consists of three phases:

- Use of "natural" methods (such as calendar method and LAM)
- Use of modern methods
- Use of permanent methods

The first phase is relational. In this phase, the couple makes different implicit or explicit agreements in order to prevent pregnancy. The first agreement the couple makes is that the woman is responsible for not getting pregnant and the man is responsible for supporting the household. (This is an implicit agreement that is established by traditional cultural norms and values within the patriarchal system in our country and especially in this population sector.)

The couple may then agree to use the calendar method or LAM. However, the couple is frequently unsure about how to use the calendar method and/or LAM.

> *"...When menstruation begins, I count 15 days..."*
> "*...We calculate the month when my menstruation comes, I protect myself for five days..."*

If the woman has used the LAM method correctly, she may have problems when the effective period for this method has ended, and she has not begun to use another method. Several of the participating women mentioned that they became pregnant during this period. Health care providers also acknowledge a higher percentage of pregnancies occurring during this period.

The second phase is defensive. Problems occur when these agreements cannot be put into practice. The factors that pose a threat to upholding the agreements include the following:

- The man wants to have sexual relations.
- The man arrives drunk.
- The man arrives from a trip and wants to have sexual relations with his partner.
- The man begins to doubt that his partner is faithful.
- The woman begins to doubt that her partner is faithful.

Women then develop creative forms of protection that have the objective of creating barriers to the possible occasions and situations during which they are pressured to have sexual relations.

*"...Sending the husband to work so he arrives tired and falls asleep. That way he doesn't bother me..."*
*"...I use protection when he comes home on leave..."*
*"...The woman throws him out of the house when she doesn't want to have relations any more..."*
*"...She goes to her mother's and returns later..."*
*"...Avoid getting into bed with the husband..."*
*"...(tells him) I'm sick, my head hurts..."*

When these creative tactics do not work women then decide to use modern contraceptive methods. They confront their fears both with respect to the methods and the position or reaction of their partners. They opt to use them.

It is in this context that health care providers claim that women do not plan and do not make agreements with their partners. If they decide to use contraception, they risk being questioned or being treated with suspicion.

There are those couples that assume the responsibility of protecting themselves (not planning), motivated by their economic and social situation, as well as the health and care of the women and of the other family members. This group uses different contraceptive methods, either alone or in combination. The couples may use the calendar method, condom, IUD, injections, abstinence or other methods that are appropriate for their lifestyle.

*"...My husband uses rubbers..."*
*"...We use the calendar method and my husband uses a condom on the risky days..."*
*"...We don't have relations all the time..."*
*"...I protect myself on my fertile days..."*

The last phase of the contraceptive strategy is to use permanent methods. These methods are recommended to and used by primarily older couples or those who have numerous children. Generally, the method is tubal ligation rather than vasectomy, which once again demonstrates that women must assume responsibility for preventing pregnancy.

In summary, the ideas expressed by the participants regarding contraceptive use are:

- Male and female study participants generally do not plan their lives, and in particular, do not plan their families. They do recognize a need to prevent pregnancy, which is addressed on a short-term (monthly) basis.

- Women or Couples have developed a contraceptive strategy that is employed implicitly or explicitly. This strategy has several phases that range from using no method, to letting God or destiny decide whether they will have children or not, to establishing a consensus supported with "natural" methods (such as calendar method and LAM).

- Faced with the failure of an agreement, women resort to creating barriers by using modern methods, such as the IUD, injections and condoms, with or without the consent of their partners; or by choosing permanent contraceptive methods, especially tubal ligation. They use them regardless of their supposed side effects.

- When comparing the data obtained on the methods offered, requested and used, it becomes apparent that the number of women who ask to use contraceptive methods is relatively small. The vast majority use no protection and no planning.

**G. Role of the Churches in the Decision to Delay a Pregnancy**

The Catholic Church and other Christian denominations exercise an influence on the decision to become pregnant. According to the data obtained, while this influence reflects the policies of these religious organizations, its application depends on the position of the priest or pastor, who forbids or allows use of contraceptives.

According to participants, for the Catholic Church, it is essential that a child be born in a formally established household; in other words, the couple must be married in civil and religious ceremonies. They do not mention other religions or sects having any position on this matter.

> *"...If it is within marriage, it is not a sin..."*

**<u>Catholic Church position on pregnancy</u>**

With respect to pregnancy, the Catholic Church and other Christian denominations consider that a child is a blessing from God, for which reason it should be protected. For this reason, all religions and sects believe abortion is a sin.

> *"...The Catholic Church says that a child is a blessing from God."*
> *"Abortion is a sin..."*
> *"...They scare us by telling us: 'if you have an abortion, you will go to Hell...'"*

Focus groups said that the Catholic Church respects the right of men and women to decide the number and timing of pregnancies.

*"...The Catholic Church does not tell you whether or not you should use protection..."*
*"...In the Catholic Church, we are more free to decide..."*

The Catholic Church supports spacing between births and provides guidance and information on how women and their partners can protect themselves. It does not obligate couples to use a specific method. According to the participants, the church most strongly promotes "natural" prevention (such as the calendar method and LAM) and dialogue between couples at the time of decision-making.

*"...They talk to you, but they don't tell you that you have to use a specific method..."*
*"...I'm a Catholic, the Church says that you can use all those things, but I don't use them..."*
*"...It is not a Church rule, it may be the initiative of some priest..."*
*"...The Church encourages spacing, but does not impose two years, for example..."*

With respect to the optimal birth spacing period, the Catholic Church assumes no formal position. It proposes considering a minimum of two years, but couples must decide how long to wait before a new pregnancy, based on their needs and expectations.

The Church's position of making decisions freely, but with information and counseling, is clear. For this reason, both men and adult women believe that while priests can make recommendations, the decision is ultimately the couple's.

*"...The priest can offer guidance, but he can't put limits on us..."*
*"...He can't force us; it depends on us..."*

**Positions of other Christian denominations**

Based on the opinions of the participants, we can say that the relationship between the faithful and their organizations requires fulfillment of certain norms and obligations. With respect to the prevention of pregnancies, the different Christian congregations maintain that women should not use contraceptive methods, but instead leave the matter up to God.

*"...It is God's decision..."*

Using an artificial contraceptive method is considered a sin and therefore there is a moral sanction. These denominations do support "natural" contraceptive methods (such as the calendar method and LAM).

*"...My family is Evangelist, they say it is a sin. The Virgin Mary didn't use an IUD, didn't take pills, she didn't do anything like that..."*
*"...My Pentecostal faith says that we should never use condoms or injections because it is a big sin. You have to protect yourself naturally..."*

Men and women who spaced their births and those who did not were not clear about whether or not information or guidance exists, for which reason we assume that if they do exist, it is a decision of the pastor or brother rather than a specific policy of the religious group.

A similar thing occurs with the spacing period. There is no clear position; rather, God decides when and how many children a couple will have.

> *"...The pastor says that two is enough, you have to wait seven or eight years..."*
> *"...You are blessed by God when you get pregnant..."*

In conclusion, the different Christian denominations have an influence on the decision to use or not to use modern contraception even for birth spacing. Use of contraceptives is considered sinful and against God's will.

**H. Birth Spacing Information that Health Services Provide**

## Norms and reference manuals

With respect to this criterion, health care providers of El Alto claim that they do not have norms to guide their work; rather, the activities implemented are the result of personal initiative and work experience in the area. Cochabamba health care providers say they have access to this information from the Basic Health Insurance office, supported by the Ministry of Health and Social Security. These are operations manuals rather than resolutions or decrees.

For these norms to be accepted and implemented, they must be prepared by the Ministry of Health and distributed to the departmental health services. Their dissemination is carried out through training of health care providers. Care is taken to assure that these norms do not include efficiency criteria that cannot be met by health care providers, which would cause them to be the first to oppose their application.

## Information provided for clients

Health care providers tell clients that they "should use protection," because it will benefit their economic situation, the health of the mother and children, as well as the future of the family. Both women who spaced their births and those who did not, reported having received this information.

> *"...They tell us we should protect ourselves..."*
> *"...We are in a crisis..."*
> *"...We have to protect ourselves to be in good condition..."*
> *"...It is for the good and future of your children..."*

Health care providers of El Alto and Cochabamba have similar criteria regarding birth spacing. They consider two years to be the minimum period, which may be extended.

> *"...At least two years..."*
> *"...If you have only one child, between two and three, if you have five, it's best to wait forever..."*

In order to enable the couple to fulfill the spacing period, health care providers from both cities offer different contraceptive methods: short- and long-term calendar, modern and permanent methods.

They affirm that they provide information on how to calculate when to become pregnant. There are differences in this regard since in some cases they calculate fertility periods according to the menstrual cycle while others do so "in terms of the age of the last child" according to birth date. Health care providers stated that they try to respect mothers' decisions. This issue is confusing for many men and women.

Finally, health care providers discuss the nutrition of the mother and child. They recommend breastfeeding to guarantee the proper nutrition of the newborn.

## Information process

Health care providers mentioned the following difficulties in their work with clients: a lack of time, language barriers, a lack of interest on the part of clients and a lack of male participation (especially in El Alto).

> *"...We have very little time to talk to them and the language barrier also has an impact. We should have a special counseling session, but we do not..."*

Adolescent and adult women from both cities were not satisfied with the treatment received from health providers, particularly physicians, because they often criticized users and made them feel afraid and ashamed. They claimed that health care providers "recommended, but did not explain," and did not understand that they are too shy to ask questions.

Health service users criticize the lack of understanding of health care providers, particularly physicians, who may become angry with them. They also complain that health care providers recommend methods but do not explain them, which often results in the incorrect use of contraceptive methods.

Health care providers say that they have little time to transmit the information and that they sometimes run into language barriers or simply face a lack of interest on the part of users, particularly men.

Finally, health care providers report that although they provide counseling, it is up to the women and especially the men to decide whether or not to use a contraceptive method and, if so, which one to use.

Summarizing the information provided by health care providers, we can say that they concentrate on promoting pregnancy prevention and the advantages it brings. They recommend waiting two years between pregnancies and offer methods women can use to prevent pregnancy. They also inform users on methods for calculating when to get pregnant and the nutrition of mothers and children, with an emphasis on breastfeeding.

## I. Sources of Information to Learn About the Benefits of Delaying a New Pregnancy

Participants underscored the need to receive information in order to make appropriate decisions regarding birth spacing. They feel that information is important and it should be well presented.

Participants said it was an advantage to be able to access information from many different sources. They specifically mentioned information from physicians, health professionals, experienced people, the family (particularly the mother) and the television.

Focus group participants recognize two information processes, interpersonal information (face-to-face) and media. With information originating from face-to-face contact, all participants agree that physicians, trained psychologists or experienced, knowledgeable people should provide this type of information.

> *"...The doctor above all; because of his experience, he knows about diseases..."*
> *"...From doctors because the nurses don't know..."*
> *"...I have more confidence in the doctor, we talk and that's it..."*
> *"...From a health professional, he is better able to counsel us..."*
> *"...From a psychologist, because he is a person who knows..."*

Participants say obtaining information from these individuals is valuable because they converse and provide explanations.

Participants said they did not want to receive information from nurses, traditional birth attendants or pharmacies because they believe they do not know enough to be able to offer concrete advice or simply because they do not know how to relate to them.

> *"...Sometimes the nurses are very unfriendly..."*
> *"...The nurses are bad while the doctor will talk to you."*
> *"Nurses, not so much..."*
> *"...We receive information only from the nurses and we don't like that."*
> *"...We don't like to get it from the family or the pharmacy..."*

In general, participants feel that nurses only give recommendations, not solutions, and treat users badly. Health care providers claim that the users are unwilling to try to understand.

Men and women believe that traditional birth attendants are insincere "charlatans," for which reason they do not consider them good sources of information.

Participants had several things to say about pharmacies. They believe that their sole purpose is to earn money and that they are not interested in people's health, which is why they never offer advice. The little information they do provide is associated with the products they sell, such as condoms, pills or injectables. When people ask questions, they are advised to consult a doctor. Participants also believe that they could receive information from knowledgeable relatives or neighbors, particularly those who are experienced.

With respect to the mass media, study participants reported that television was the best medium since it offered varied programming that provided information about a variety of subjects. They felt that the radio was not a good information source and served only for listening to music. They believe that these media should disseminate information by providing good explanations for longer periods.

They suggest that other media, such as leaflets and posters, could be complementary sources of information. These materials should use illustrations and images that clearly present the information. These media complement the other media.

Participants had no definitive opinion regarding the inclusion of birth spacing information with that on contraceptive methods; some believed it could be useful for people who use these methods, but others did not think so because they do not know how to read or because they do not use contraception.

> *"...It depends, if people know how to read, yes, but for people who don't, it doesn't matter..."*
> *"...I think it would be useful because we are always curious about what it says there..."*

Summarizing the data obtained with respect to information sources for delaying pregnancy, we can say that women, health care providers and men believe it is essential to have accessible, clear information. Information should be of good quality and presented in all possible forms, both interpersonal information (face-to-face) and media.

The most valued information sources are those that combine knowledge, capacity, experience and good treatment, for which reason the participants preferred doctors, psychologists, health professionals, as well as experienced family members, friends and neighbors.

Participants do not consider nurses or traditional birth attendants reliable sources of information because they do not believe they are very knowledgeable, and they do not treat users well.

They view pharmacies as businesses that are interested only in earning money rather than in the welfare of families, for which reason they are not considered good information sources.

With respect to the possibility that information on birth spacing can be presented along with contraceptive information, study participants reported that it may or may not be useful, depending on the target audience. Some participants cannot read but others are interested in reading everything they can.

## V. CONCLUSIONS

Based on the data obtained and the analysis of results in this report, the following conclusions are proposed. Because these are the conclusions of a qualitative study, they should not be generalized but rather considered as a tool for discussion.

## A. Advantages or Disadvantages of Delaying a New Pregnancy

### Advantages

Economic: Participants report that spacing has advantages for the family in economic terms since, by not incurring costs of supporting a new child, they are able to save and satisfy the needs of the last child. Women also have more opportunities for working, thereby helping the partner to maintain the household.

Family relationships: All family members have more time and freedom, which permits them to offer better care to the newborn and pursue their personal development. The mother can spend more time with her children with affection, knowledge and tranquility. She can also pay more attention to her partner. The man has more time to work and spend time with his children.

When couples are not subject to strong economic pressures, they seem to enjoy a less tense relationship. The family members receive increased respect and affection, especially children, who are not subjected to an environment of discord.

Spacing brings advantages for the family economy, health of the mother and the child, as well as care and personal development of family members. It helps to create a positive family environment.

Woman's health: Birth spacing allows the woman to recover from her last pregnancy, heal her body, allow her womb to return to its normal state, recover lost nutrients and improve her defenses. It also helps her to avoid illness and reduce complications during her next pregnancy.

Benefit to child**:** Children who are born after an appropriate interval enjoy good health and are eagerly awaited by their parents, for which reason they receive greater affection and have greater possibilities of receiving quality breast milk for a longer period. Both mother and child are healthier.

### Disadvantages

Participants stated that disadvantages are associated with relationships. Birth spacing may affect the couple's sexual activity, because a contraceptive method must be used, and if not used, the frequency of relations must be reduced. These decisions provoke different reactions and feelings, ranging from insecurity, to jealousy and anger, which may even lead to separation in some cases.

Another disadvantage is the potential problematic relationship between siblings. The greater the difference in age, the less compatible siblings are in terms of play and the relationship itself.

Birth spacing can also affect the relationship between children and their parents, who may have begun work or education activities. Because of the birth of the child, they may not have enough time and may be forced to give up these activities to resume their primary role as caretakers.

Common to all groups was the lack of awareness of the risk of adverse outcomes if there are short birth spacing intervals because none of them mentioned adverse physical impact on the mother, the last child, or the child to be born.

### B. Reasons that Favor Delaying a New Pregnancy

Adolescent mothers, adult women, men and health care providers believe that the main reason for delaying a new pregnancy is their precarious economic situation. Additionally, they are concerned about the health of the mother and the care and development of the children already born or to be born.

### C. Amount of Spacing between Pregnancies

The participants used the analogy of the earth, which, if left to rest, can produce good fruits. In general, participants agreed that two years should be the minimum spacing period; very few mentioned up to five years.

Unfortunately, this spacing period is not achieved due to a lack of information or because of the *macho* culture in which the man makes the decision to have sexual relations, without regard for the risk of pregnancy, and women are unempowered to make these decisions.

### D. Which Partner Makes the Decision Regarding Another Pregnancy

In practice, couples do not make decisions about new pregnancies; rather, pregnancies are usually the accidental result of the satisfaction of the couple's sexual needs, particularly the man's (the man decides most frequently when to engage in sexual relations; in some cases, the decision may lead to violence).

Based on the study findings, this population group does not have a concept of the family that fosters a partnership between the couple; rather it has a concept of the traditional family in which the children are the center of the relationship. The mother is responsible for their care, and the father provides the economic outcome.

In the few cases in which the couple actually discussed whether to have more children, the woman plays a greater role in the decision-making process since she is the one who will carry the child and who will be the main caretaker.

### E. Family or Community Member Who Influences the Decision Regarding a New Pregnancy

Because of the traditional characteristics of families in the population group, women (mothers, mothers-in-law, sisters, sisters-in-law and aunts) of the couple's families exercise an influence by giving advice or imposing their views, especially moral, with regard to the need to hurry or delay the next pregnancy.

Friends in the case of adolescent women, and neighbors in the case of adult women, also influence the decision, although their influence is less marked. The mass media, the church and health care providers offer information but do not determine changes in birth spacing.

## F. Health Services Role as a Source of Information on Delaying Pregnancies

Health services providers see themselves as offering information on birth spacing, which includes information on using protection, the advantages of this decision, the recommended spacing between pregnancies (more than two years), methods for calculating when to get pregnant and promotion of breastfeeding.

Participants said negative aspects were that the information offered did not achieve the necessary impact due to the fact that health care providers did not have much time for this activity; the channels in which counseling is offered are inadequate; occasionally there are language barriers that impede communication; and health care providers do not work with men, who are usually the ones ultimately making the decision.

Participants report that health care providers only make recommendations without giving explanations. They also claim that nurses treat them poorly and that doctors do not understand them. Participants also say they are too afraid or ashamed to ask questions, which angers nurses.

## G. Information Sources to Learn About the Benefits of Delaying a New Pregnancy

The community values access to information on how to prevent new pregnancies. This information should be provided by sources with sufficient knowledge, capacity and experience, for which reason participants believe the most adequate sources are doctors, health professionals, psychologists, as well as knowledgeable, experienced family members, friends and neighbors.

While they would like to access this information through as many sources and channels as possible, they prefer information to be transmitted face-to-face, because it offers an opportunity for explanation and interaction.

They do not believe nurses, pharmacies, traditional birth attendants and the radio are good sources of information. In the specific case of pharmacies, study participants consider them as businesses that are more concerned with profits than with people's health, for which reason they are not good sources of information.

With regard to the question of whether or not information on birth spacing should be included with information on contraceptives, participants reported that it would be useful for some people. However, they pointed out that most people use other contraceptive methods, and many cannot read.

## H. Contraceptive Strategies

With regard to contraceptive methods, there is no relationship between knowledge, attitudes and practices. Whereas participants are familiar with the different methods (although they do not know how to use them correctly), most of the adolescent mothers, adult women and men in both cities said they do not use a contraceptive method.

Their first option is to use "natural" methods (such as calendar method and LAM) combined with an agreement with their partners. Motivated by the failure to prevent pregnancies using these methods, either because they are not properly applied due to a lack of

knowledge or because agreements are not respected, they request modern methods such as the IUD, Depo-Provera injections and condoms, in the case of younger couples.

This choice is shrouded in fear because participants believe that the IUD and injections cause cancer or hormonal disorders. Additionally, women are fearful that their partners will not accept their decision to use contraceptives.

The most requested methods at health centers are the IUD and injections. Although fearful of side effects and the reaction of their partners, they chose these options because of their effectiveness and the fact that they do not produce changes in sexual relations with their partners. For younger individuals and women who choose to use contraceptives as a couple, the condom is a good method. However, many of the women did not use any method.

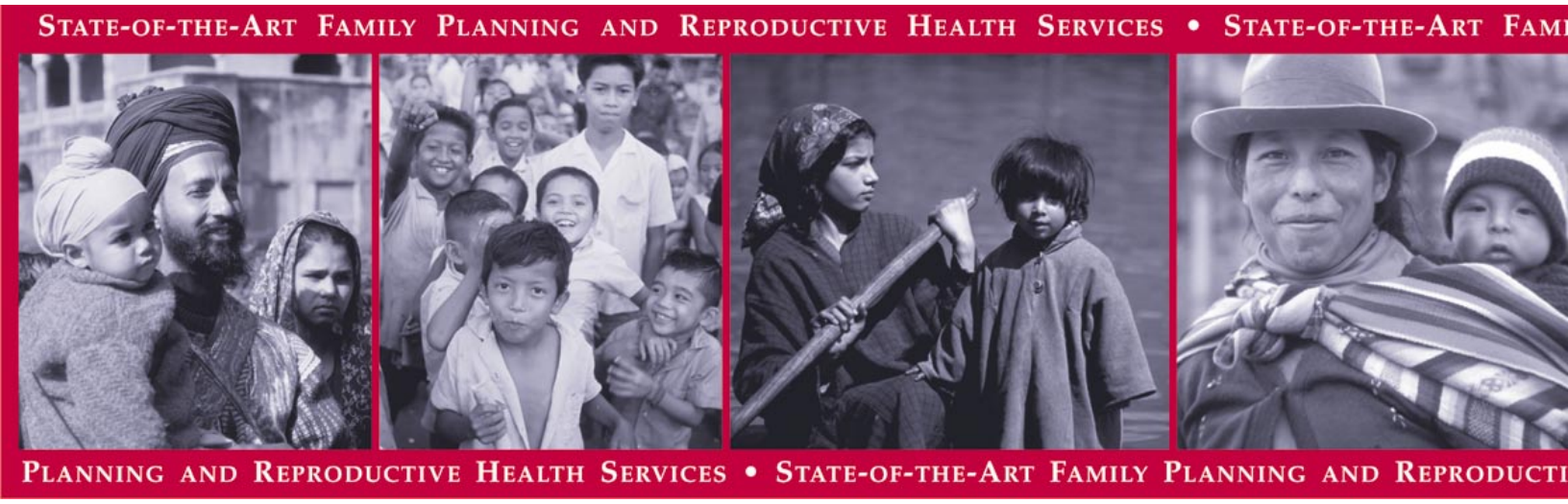
## I. Other Conditioning Factors

Study participants belong to or work with the poor population with a traditional view of life and a paternalistic concept of the family. This system of values assigns women the responsibility of caring for the home and the children while the man works to provide income for the home and the family's future.

This system subordinates women, limiting their development due to a lack of education, restricted access to employment and widespread acceptance of domestic violence. This context has affected the self-esteem and self-image of women.

The assigned maternal role conceives of the woman as someone who serves others rather than as a person in her own right. Her children are the main reason for her existence. Her relationship with her partner focuses on sexual activity, particularly motivated by the man's sexual satisfaction, without regard for the risks of pregnancies. Men may become violent or simply ignore the woman's right to refuse sexual contact.

The community's relationship with health services is usually limited to primary care facilities located in peri-urban areas of El Alto and Cochabamba, which do not have the resources necessary to provide friendly, quality service, expressed in the poor treatment offered by providers. Additionally, the few pharmacies within the population's access are little more than drugstores, which do not provide answers to their reproductive health questions.




CATALYST
consortium

Catalyst Consortium
1201 Connecticut Avenue, NW, Suite 500
Washington, DC 20036
T. 202.775.1977
F. 202.775.1988
www.rhcatalyst.org

Partners:
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